Patient Health Information

Patient Name___________________________________ Birthdate_______________ Today's Date_____________

Why did you come to the clinic today? ____

____

Are you experiencing any of these problems? (please circle all that apply):

Anxiety	Diarrhea	Skin Problems	Weakness of Arms/Legs
Back Pain	Fainting	Sore Joints	Weight Loss or Gain
Breathing Problems	Headaches	Stomach Pain	
Chest Pain	Nerve Problems	Vision Problems	
Depression	Problems with Urination	Vomiting	

Until now where were you receiving medical care? ____

Who was your physician?___________________When was the last time you went to a doctor? (date)__________

To a dentist? (date)__________________ To the eye doctor? (date)_________________

Where did you get your medications? (drugstore name) ____

Do you have any ongoing health problems? Y or N If yes, please list:_________________________________

SOCIAL

Tobacco Use (circle one): Never Rarely Moderate Heavy Quit Years:_____ Packs Per Day:_____

Alcohol Use (circle one): Never Rarely Moderate Heavy Quit

Drug Use (circle one): Never Rarely Moderate Heavy Quit

Caffeine Use: ______ Cups per Day Exercise Activity: _______ Events per Week

Patient Signature:__________________________

MEDICAL HISTORY – To be reviewed with nurse

ALLERGIES

Allergy	**Response**	**Date of Onset**

FAMILY HISTORY

Relation	**Disease**	**Deceased: Y or N**	**Death Age**

PATIENT HISTORY

- ☐ Allergies
- ☐ Anemia
- ☐ Anticoagulation
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding
- ☐ Bowel Disease
- ☐ COPD
- ☐ Depression
- ☐ Dental Disease
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Eye Disease
- ☐ Epilepsy
- ☐ GERD
- ☐ Gout
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Other (please describe): ______________________
- ☐ Liver Disease
- ☐ Low Back Pain
- ☐ Major Blood Pressure Disorder
- ☐ Mental Illness
- ☐ Migraines
- ☐ MS or Nerve Disease
- ☐ Musculoskeletal Disorder
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Obesity
- ☐ Peripheral Arterial Disease
- ☐ Prostate
- ☐ Thyroid
- ☐ Transfusions
- ☐ Skin Disorder
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Cancer
- ☐ Heart Disease
- ☐ Sexually Transmitted Disease

Please explain any of the conditions including type of disorder, date diagnosed, etc.: ______________________

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PATIENT'S CURRENT MEDICATIONS: ***Use additional pages if necessary***

Name	Dosage	Form: Pill, Liquid, Powder, etc.

PATIENT HOSPITALIZATIONS OR SURGERIES: ***Use additional pages if necessary***

Date	Hospital	Surgery Type	Reason

NURSE'S SIGNATURE____ DATE_________________________

FOR INTERNET USERS: Please phone **814-534-6242** to schedule an Intake appointment.
Please bring: proof of income, identification, this form, Patient Demographic Sheet